

Application for Insurance Premium Payment Assistance

TEXAS DEPARTMENT OF HEALTH
Chronically Ill & Disabled Children's (CIDC) Services Program
1100 West 49th Street Austin, Texas 78756

Phone #: 1-800-252-8023 x3058 Client/Parent fax #: 1-800-441-5133

PART 1 - Applicant Information

Applicant's Name: _____ CIDC Case#: _____

Parents' Name(s): _____ Phone #: ()

Address: _____

(Street)

(City, State)

(Zip Code)

Name of Insured: _____ Social Security #: _____

Name of Employer: _____ Phone #: ()

Address: _____

(Street)

(City, State)

(Zip Code)

Insurance Company: _____ Phone #: ()

Address: _____

(Street)

(City, State)

(Zip Code)

Group #: _____ Applicant's Policy #: _____

Policy Type: (✓ all that apply) ☐ HMO ☐ PPO ☐ COBRA ☐ Major Medical ☐ Other: _____

If you do not know what type of policy you have, please send us a copy of your policy or Summary of Benefits.

Coverage Type: (✓ one) ☐ Employee Only ☐ Full Family ☐ Employee/Child ☐ Child Only ☐ Other

Is there a prescription drug card? ☐ Yes ☐ No Prescription card Co. name: _____

Address: _____ Phone #: ()

(Street)

(City, State)

(Zip Code)

How is your premium payment made? ☐ Payroll deductions ☐ Personal check ☐ Money Order

☐ Automatic bank draft ☐ Other _____

Premium amount paid per month: _____

List services not covered by your insurance company: _____

For us to consider your application, you must enclose: acceptable proof* of last month's premium payment; and a front and back copy of the applicant's insurance ID card.

*The various types of acceptable proof of payment are described in the enclosed letter.

Signature: _____ Date: _____

This application will not be considered complete unless it is signed